

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

Our Quality Management System

1. Introduction

The Trust uses a Quality Management System to support the effective integration of the interdependent aspects of 'quality' into the Trust's Escalation and Assurance frameworks.

Figure 1: The Focus of our Quality Management System



The **Quality Oversight System** supports the 'surveillance', 'understanding', 'managing and escalating' and 'learning and improving' elements of the System. The Trust's **Organisational Learning and Response System** is embedded in the Quality Oversight System. The Trust's **Risk Management Strategy** provides a procedural infrastructure, alongside other key policies, for the managing and escalating elements of the system. The Trust's Board, Board Committees and their Sub-Committees provide a **Quality Governance** infrastructure for the assuring elements of the system.

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

2. Our Quality Oversight System

The principles of the Quality Oversight System in use in the Trust are as follows:

- It is patient focussed – members are grounded in the fact that their purpose is to maintain good quality services for patients
- It is high trust – an environment which facilitates open and honest conversations about quality
- It is inclusive – all members feel able to contribute to discussion
- There is appropriate challenge – Members feel able to offer constructive challenge to colleagues to get to the bottom of the issues and identify suitable actions
- It is action orientated – all members come away from meetings with clarity as to the actions agreed and who is taking them forward
- It is well informed – members receive reports and data-packs which present information in a useful and distilled format to members which enable them to identify the potential quality risks
- It is comprehensive – the system has a planned and defined business cycle which enables them to consider potential risks in all areas within their remit, across Care Groups and Corporate Departments.

As well as specific incidents and events in the Trust the oversight system has developed the capability to consider

- care pathways including effectiveness data
- ward and service level intelligence, intelligence related to specific patient characteristics for example, patients with dementia, cancer patients, children, vulnerable adults etc.
- quality themes and trends for example within data relating to falls, pressure ulcers, serious incidents, complaints
- staffing issues including engagement, turn over, capacity and demand

The Quality Oversight Systems consists of a defined infrastructure and a range of processes to ensure that the organisation has early sight of any emergent risk to the quality of care that we provide. This includes risk to the health and safety of patients, visitors to the Trust and staff.

2.1 Our Quality Oversight System: Infrastructure

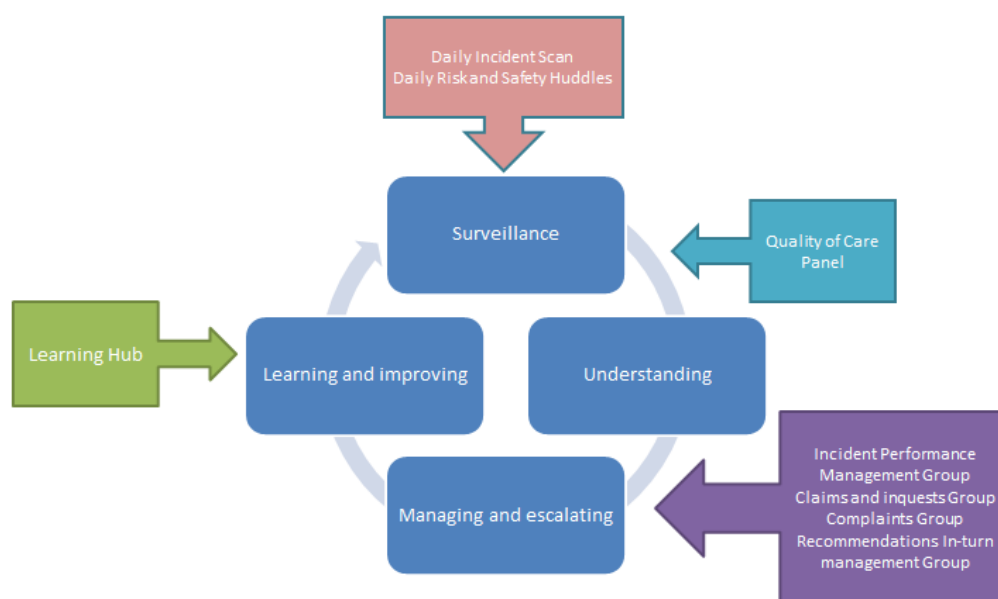
One of the key strengths of the Quality Oversight System is the infrastructure which has been designed to enable multi-disciplinary scans of our incident management system, and our daily service level risk and safety huddles across the Trust, culminating in a daily Trust

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

Wide Risk Huddle, which takes place at 12pm every working day. The key questions that are posed daily are as follows:

- Were we safe yesterday?
- Are we going to be safe today?
- What future risk could be on the horizon?

Figure 2: Our Quality Oversight System: Infrastructure



The **Quality of Care Panel** is designed to ensure executive leadership clear line of sight through the care provision and operational activities of the Trust, to ensure any past, present or future potential or actual unmitigated risk to the quality of our services has been captured, is understood and is being acted on and learnt from appropriately. The Panel meets every week and uses a range of intelligence including serious incident referral forms, serious incident exception reports, serious incident investigation reports, soft intelligence (internal/external), quality /Performance dashboard data, national alerts and relevant national intelligence to ensure that risks are understood, serious incidents are recognised and appropriate measures are taken to safeguard patients or improve the quality of care.

The **Management Groups** are all designed to support the identification of precursor incidents (which are identified from complaints, claims, incident reporting, inquests, mortality reviews, patient experience information, ProgRESS reviews, effectiveness data information from regulators and external partners, staff and patient conversations and a quarterly focus group of the learning and surveillance hub) from the information that they hold or receive,

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

and ensure that they are being managed and escalated appropriately. All the management groups have care group representation as part of their membership.

The **Learning Hub** acts as a virtual team across the Trust, bringing together all Care Groups and Corporate Departments and their respective information and intelligence, gathered through performance monitoring, and regulatory activities.

It is designed so that all members feel ownership and responsibility for the effective operation of the group. By collectively considering and triangulating information and intelligence, members work to safeguard the quality of care that people receive through learning and translation into practice activities (see section 3; our Knowledge Management System).

Members are a network of partners who work together and share information in the interests of patients and service users. This work is not confined to formal meetings. The Learning Hub can act as a virtual network in between meetings, with members interacting with each other in smaller groups where appropriate.

2.2 Processing, review and consideration

In order to generate meaningful and succinct intelligence from the vast amount of processing, review and consideration that occurs within the system, a standardised process across the oversight system is used, as reflected in table 1, to ensure that the organisation has oversight that gives assurance that the organisation is making real progress in relation to supporting a mature learning culture.

Table 1: Processing, review and consideration

		Mechanism	Output
Preparation	Assimilation of locally held data associated with complaints, litigation, incidents and coroner's inquests, mortality reviews, effectiveness data,	Daily Huddle Weekly QuOC Weekly IPMG Quarterly analysis Complaints Group Claims Group	Key Findings
Review	Analysis of type, causation, contributory factors and associated learning	Thematic review Quantitative analysis	Assessment
Evaluation	Escalation of areas of significant concern, initiation of thematic reviews to explore areas of potential concern, identification of opportunities for Trust-wide learning. Exploration of tacit experience and case studies	QuOC IPMG Divisional governance Learning and Surveillance Hub Sub-Committees	Risk and control identification (see table 2)
Report	Completion of outcome report of full review and recommended actions	Quality Committee	Assurance

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

This processing of information is directly supported by the Office of Governance and Corporate Affairs, the Offices of the Chief Medical Officer and Chief Nurse and by key clinical and operational staff from the Care Groups through the various structures and mechanisms within the system.

A process of risk and control identification underpins the quality oversight system and is described in Table 2. The outcome of this also assessment directly influences the choice of 'learning categories', and subsequent learning modality and dissemination (see section 3).

Table 2: Risk and Control

Risk and Control		
Significant concern	Escalated for discussion and action at QuOC Reported to Integrated Governance and Risk Committee, Patient Safety Committee (and other relevant sub-committee of the Quality Committee) and through Care Group governance	Risk (see section 4)
Concern	Escalated for discussion and planning at Incident Performance Management Group/Complaints Group/Care Group governance. Referral for responsive ProgRESS review considered	Risk (see section 4)
Opportunities for Change and improvement	Referred for discussion and care group governance for action and support through the Learning Hub and relevant sub committees of the Quality Committee	Opportunities for change and improvement
Good practice	Referred for discussion and divisional action support through the Learning and Surveillance Hub and relevant sub committees of the Quality and Safety Committee	Opportunities for learning

The Quality Committee (see section 5) receives the following specific outputs from the Quality Oversight system:

- Monthly Quality Oversight System Summary
- Monthly Serious Incident Report, describing Serious Incidents declared and those where the investigation has been concluded
- Quarterly Incident Report
- Quarterly Effectiveness report
- Quarterly Patient Experience report

3. Organisational Learning and Response System

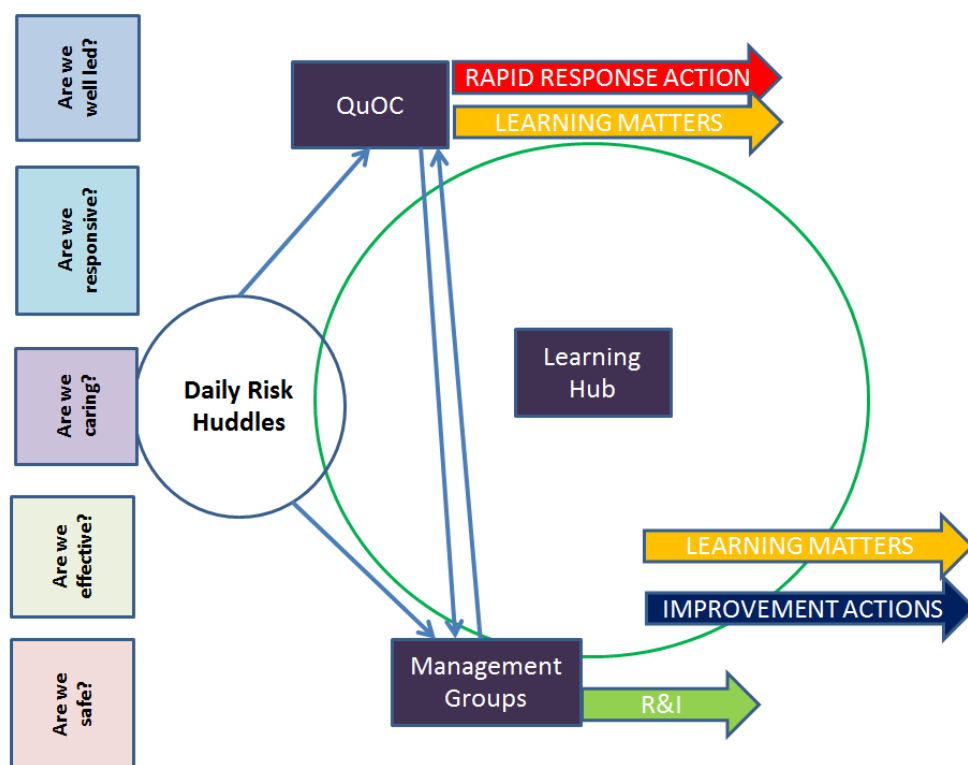
During 2016/17 the Trust developed and implemented a knowledge management framework allowing creation, acquisition, dissemination and implementation of this knowledge across the organisation. This system, the 'organisational learning response system', enables precursor incidents (which are identified from complaints, claims, incident reporting,

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

inquests, mortality reviews, patient experience information, ProgRESS reviews, effectiveness data information from regulators and external partners, staff and patient conversations and a quarterly focus group of the learning and surveillance hub) to be used in a learning process to support Trust-wide change and improvement and contribute to the avoidance of future incidents and the mitigation of risk.

The organisational learning and response system is embedded in the organisations ‘Quality Oversight System’, which is represented in Figure 2. The key learning outputs from this system are represented in Figure 3 and described in more detail in Table 3.. The term incident is used to refer to any sort of ‘precursor incident’ that can support the generation of learning.

Figure 3: Key learning outputs from the Organisational Learning and Response System



The Quality Committee receives a quarterly report from the organisational learning and response system, describing the precursor incident, the learning identified and how that learning was disseminated across the Trust.

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

Table 3: Trust wide feedback mechanisms


Trust wide feedback mechanisms			
	Type	Content	Responsibility
Bounce-back	Contemporaneous feedback to reporter (part of incident management process)	Acknowledge report filed (eg automated response) <ul style="list-style-type: none"> • Debrief reporter (eg telephone debriefing) • Provide advice from safety experts (feedback on issue type) • Outline issue process (and decision to escalate) 	Care Group Risk Management Complaints
Rapid response actions	Action within local work system	<ul style="list-style-type: none"> • Measures taken against immediate threats to safety or serious issues that have been marked for fast-tracking • Temporary fixes/workarounds until in-depth investigation process can complete (withdraw equipment; monitor procedure; alert staff) 	QuOC Care Group
Risk awareness information	Information to all frontline personnel	<ul style="list-style-type: none"> • Safety awareness publications ‘Learning matters’ (posted/online bulletins and alerts on specific issues; periodic newsletters with example cases and summary statistics) 	Learning hub Care Group
Publicising actions taken	Information to all personnel	<ul style="list-style-type: none"> • Report back to reporter on issue progress and actions resulting from their report • Widely publicise corrective actions taken to resolve safety issue to encourage reporting (e.g. using visible leadership support) 	Care Group Risk Management Team/Assurance team
Improvement actions	Action within local work systems	<ul style="list-style-type: none"> • Specific actions and implementation plans for permanent improvements to work systems to address contributory factors evident within reported incidents • Changes to tools/equipment/working environment, standard working procedures, training programs, etc. • Evaluate/monitor effectiveness of solutions and iterate 	Care Group Learning Hub ProgRESS team

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

4. Risk Escalation Framework

The Trust's Risk Escalation Framework is clearly defined in the Trust's Risk Management Strategy (2019-2025). Our risk management strategy is designed to strengthen our ability to achieve our strategic objectives and business targets thus ensuring the continuation of the safe and effective delivery of our services. It does this by supporting our strategic and operational decision making and planning, helping us to comply with legal and regulatory requirements, improving our governance and controls and ensuring an open culture where people feel encouraged to take responsibility for minimising any negative effects of risk on our services and support improvements to the safety of the services

Table 4: Risk escalation framework



Risk identified and assessed	An initial discussion takes place with a line manager (and the Care Group/Specialty/Corporate Directorate Governance Lead for assistance if required) and then be assessed, graded and added to the risk register as appropriate
Ward/specialty/corporate service level	Monthly review of risks is undertaken at ward/specialty/corporate service level. Where the ward specialty or department feel unable to manage the risk this should be formally escalated to the Divisional Governance Lead for consideration at next meeting
Care Group/Corporate Department Level	Monthly review of risks escalated formally from ward/specialty/corporate service and all risk scored at 9 or greater to be reviewed at divisional level. Where the Division/Department feel unable to manage or address the risk themselves this should be escalated formally to the Corporate Risk Register. This is to be undertaken by checking the box escalate to corporate risk register on Datix and by informing the Director of Governance and Corporate Affairs in writing
Strategic level	<p>The Integrated Governance and Risk Committee reviews all risks newly escalated, considering whether to accept them onto the strategic risk register. Risks accepted are identified with an executive lead.</p> <p>All risk on the strategic risk register scoring greater than 12 are reviewed monthly at the Integrated Governance and Risk Committee., and managed within the principal risk structure of the register to enable alignment to the Board Assurance Framework (BAF)</p>
Committee Level	Board committees will review the principal risks and their component risks assigned to them and consider their impact on the Board Assurance Framework and how they should be reflected
Board Level	The Board reviews a high level register of Trust wide risks graded at 15 or greater at each meeting. The Board reviews its strategic risks (12 or above) via the BAF, receiving assurances from the Board Committees and undertaking a review of all BAF risks at each meeting.

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

The strategy makes it clear that the Trust manages risks at a strategic, Care Group, Clinical Business Unit and service level.

Strategic risks are risks that have the potential to impact significantly on the Trust's strategic objectives or organisational risks that apply to the organisation as a whole and cannot be managed at Care Group level or are considered a risk to the delivery of the Trust's strategic objectives. These are reflected on the Strategic Risk Register Service level risks are risks that, having been assessed as active in relation to their likelihood and consequence, and following assessment, are considered appropriate to be managed and mitigated at Care Group, Clinical Business, Specialty or department level. Service level risks can also be managed through the Corporate infrastructure of the Trust, at Corporate Directorate or team level.

The risk escalation framework is presented in Table 4 and is supported by the governance infrastructure described in Section 5 and the roles and responsibilities of staff across the Trust described in the Risk Management Strategy.

5. Quality Governance

The Board of Directors established a Quality Committee (see Figure 4) to provide it with an objective and independent review (including relevant strategic risks and associated assurance) of the quality of the care the Foundation Trust provides. This remit includes a focus on the Care Quality Commission (CQC) domains of safe, effective, caring, responsive and well led, and on also on the effectiveness of quality governance and risk management (including health and safety) systems.

The objective of the Committee is to enable the Foundation Trust Board to obtain assurance that high standards of care are provided and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Promote safety, high quality patient care across the Foundation Trust
- Identify, prioritise and manage risk arising from clinical care
- Ensure the effective and efficient use of resources through evidence based clinical practice
- Ensure that the Trust is aligned to the statutory and regulatory requirements relating to quality and safety
- Protect the health, safety and wellbeing of Trust employees
- Ensure effective information governance across the Trust's functions.

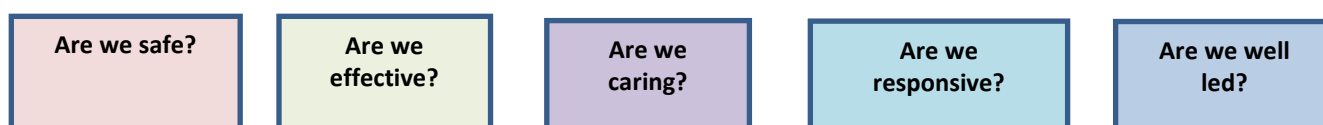
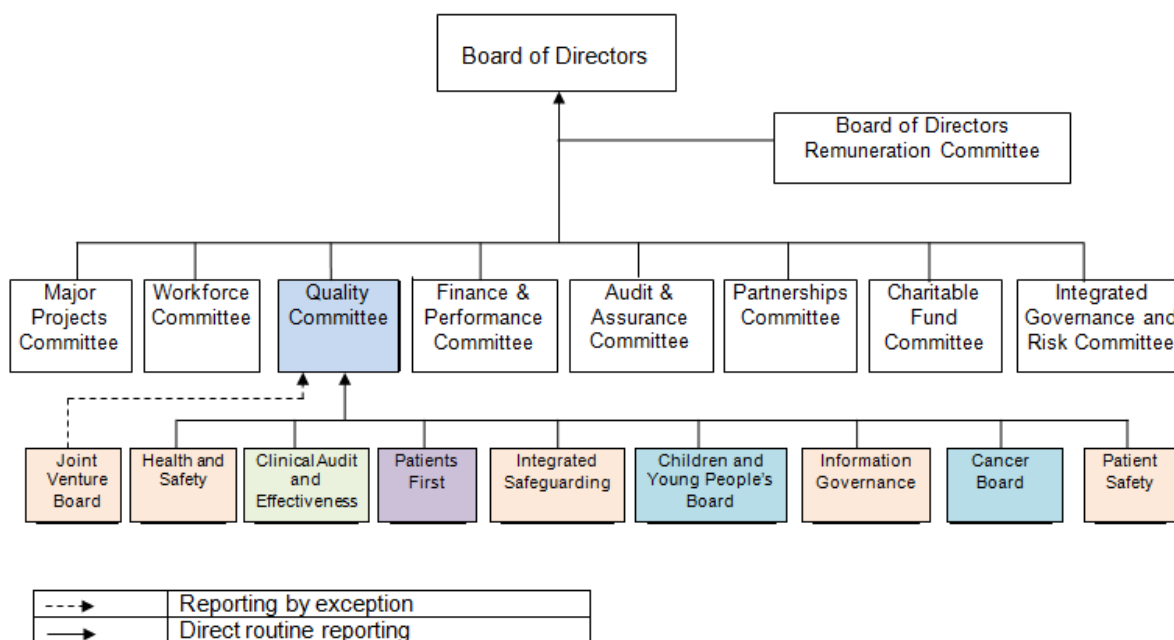
The principal duties of the Committee are:

- To receive and review the strategic objectives related to quality allocated to it by the Board of Directors, agreeing the key controls and identifying any areas where routine and additional assurance is required within its work-plan and what type of assurance is required.

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

- To receive and review the Board's Risk Appetite statement at each meeting and apply it to their review of the risks and assurance associated with the Trust's Strategic Objectives.
- To receive and scrutinise the Strategic Risks (with a risk score of 12 or more) or any other risks identified or being managed by the Trust allocated to it by the Board of Directors in the context of the Board Assurance Framework, monitoring progress made in mitigating those risks through the work of the Integrated Governance and Risk Committee, identifying any areas where additional assurance is required.
- To report to the Audit and Assurance Committee, as per the memorandum of understanding and provide assurance to the Trust Board on the adequacy of control and mitigation against such risks.
- Following consideration of the assurances received through the discharge of its operational responsibilities, agree the level of confidence the Committee has in relation to the achievement of the strategic objectives allocated to it and provide the associated rationale for inclusion within the Board Assurance Framework.

Figure 4: Quality Committee and its associated governance and infrastructure



Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, information governance, research & development; and the regulatory standards of quality and safety.

The Committee discharges this responsibility through:

- Assuring that safety, effectiveness, and patient experience across all the Foundation Trust's services is compliant with the CQC's Fundamental Standards of Quality and Safety
- To review and monitor delivery of the Foundation Trust's Quality Plan and any supporting implementation plans
- Contributing to and overseeing the development of the Foundation Trust's annual Quality Report
- Determining and monitoring the programme of clinical risk management and clinical audit
- Having oversight and scrutiny of the risks and assurance associated with the impact of financial and performance pressures on the quality of care
- Reviewing and assuring processes for quality impact assessment of Trust developments and cost improvement schemes.
- To review reports about compliance with external quality standards, including the Fundamental Standards of Quality and Safety, NHS Trust Litigation Authority requirements, Health and Safety legislation and regulation, and to review the adequacy of relevant formal Trust disclosure statements prior to endorsement by the Foundation Trust Board.
- Having oversight and scrutiny of the programme of work to move the CQC rating of the Foundation Trust to 'good' or 'outstanding'
- Informing the development of the corporate objectives and priorities for inclusion in divisional annual plans
- Having oversight and scrutiny of the Foundation Trust's Information Governance arrangements.
- To make recommendations to the Audit Committee concerning the annual programme of Internal Audit work and to work with the Audit Committee to ensure effective scrutiny of the risks and systems of internal control related to matters of quality and safety.

The Committee also reviews all aspects of quality within the Foundation Trust through examination of:

- Serious Incidents, Infection Prevention and Control, Safeguarding, Patient Experience, mortality and other relevant reports
- Regular highlight reports from the Sub-Committees
- National reviews and inquiries which involve systems failure.

The Committee has a range of standing agenda items to ensure that it can effectively escalate any risks, gaps in controls or gaps in assurance to the Board of Directors. These items include:

- Board Assurance Framework
- Strategic Risks relevant to the Committee

Meeting Title	Board of Directors		
Date	24 April 2019	Agenda item	Bo.5.19.12 Appendix 1

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- Quality Dashboard
 - Exception reports from established Sub-Committees
 - Matters to share with other Board Committees
 - Matters to Escalate to the Strategic Risk Register
 - Matters to Escalate to the Board of Directors
 - Items for Corporate Communications

The Committee receives written update reports following each meeting of the Sub-Committees below which details the business undertaken on its behalf.

The Committee Chair reports formally, regularly and on a timely basis to the Board of Directors on the Committee's activities by:

- Providing a written update report (including detailed commentary on the assurance received and risks identified in relation to the key controls identified within the Board Assurance Framework) following each meeting and the presentation of an annual report for each of its operational responsibilities including the relevant content for the Foundation Trust Quality Account
- Bringing to the Board of Director's specific attention any significant matter under consideration by the Committee.
- Ensuring appropriate escalation arrangements are in place to alert the Foundation Trust Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise the delivery of the Foundation Trust's Strategic Objectives.
- Providing a report to each meeting, as per the agreed memorandum of understanding of the Audit and Assurance Committee, focused on the management of key risks within its terms of reference using the summary of the Strategic objective(s) used to populate the Board Assurance Framework.
- If issue is raised which needs immediate escalation, or action taken, which is outside of the remit of the Committee this is escalated to the appropriate Executive meeting, via the chair, for discussion and action.